1522 17th Street
Lewiston, ID 83501

(208)743-8416
clearwatermedclinic.com

Patient Information Form

Name: _____
Last First Middle

DOB: _____/_____/_____ **Gender:** Male ☐ Female ☐

SS#: _____-_____-_____

Mailing Address : _____
City_____**State**_____ **Zip** _____

Physical Address: _____
City_____**State**_____ **Zip** _____

Home Phone: ( ) _____-_____
Cell Phone: ( ) _____-_____
Work Phone: ( ) _____-_____

Confirm Appointments via TEXT? **Yes** _____ **No** _____
Phone Service Provider: _____
Confirm Appointments via EMAIL? **Yes** _____ **No** _____
Email Address: _____

Status: Single ☐ Married ☐ Divorced ☐ Widowed ☑
Race: White ☐ American Indian ☐ Hispanic/Latino ☐
African American ☐ Oriental/Asian ☐ Other ☑
Employer: _____
Employer Phone: ( ) _____-_____

Emergency Contact: _____ **Relationship:** _____
Phone: ( )_____-_____

Emergency Contact: _____ **Relationship:** _____
Phone: ( )_____-_____

Primary Insurance: _____
ID#_____ Group#:_____
Eff Date: _____ Co-Pay? _____
Policy Holder: _____ DOB: _____/_____/_____
Relationship to Patient: _____

Secondary Insurance: _____
ID#_____ Group#:_____
Eff Date: _____ Co-Pay? _____
Policy Holder: _____ DOB: _____/_____/_____
Relationship to Patient: _____

Responsible Party if other than Patient or if Patient is a Minor

Name :_____ DOB:_____/_____/_____ SS#_____-_____-_____ Relationship: _____

Address:_____ City: _____ State: ____ Zip: _____ Ph#: ( )_____-_____ Employer: _____

Previous Provider/Current Medications (New Patients Only)

Previous Primary Provider: _____ Facility:_____ Reason for leaving? _____

Medications/Dose:

Consent for Treatment:
I hereby authorize necessary medical care to be rendered to the patient registers hereon.

Assignment of Benefits/Medicare Lifetime Signature (Medicare Patients Only)
I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to CLEARWATER MEDICAL CLINIC for services furnished to me by that provider. I authorize any holder of medical information about me to be released to CMS, its agents, and/or insurance carrier any information needed to determine the benefits payable for related services.

Financial Responsibility:
On delinquent accounts (60 days past due) there will be a service charge for 21% per annum (applies to non-Medicare patients only). I understand I am responsible for payment of my account regardless of insurance coverage. My signature certified that I have read and understand the statements above.

_____ _____ _____
Signature of Patient/Responsible Party Printed Name of Patient/Responsible Party Date